ABBOTSFORD
SCHOOL DISTRICT
LEARNING SUPPORT SERVICES

OT/PT Full Referral Requirements

The school must submit the following 2 forms* to Learning Support Services:

1. Cover sheet – School District Referral to LSS
2. Fraser Valley Child Development Centre Referral for Service

Prior to consultation, CDC will have the following two forms filled out:

1. Consent for Service
2. Consent to Obtain/Release Information

*Samples of the forms are below. School District Staff can access the forms on Abby Connect at:
https://abbyconnect.sd34.bc.ca/ (LSS Department – scroll down to forms)

School District #34 (Abbotsford)
Learning Support Services

For Office Use Only
Referral to _____ for action/follow-up
Date received by Learning Support Services _____

PLEASE SEE BACK PAGE OF REFERRAL FORM FOR PROCESSING INSTRUCTIONS

Student Information School Name: _____ Referral Date _____ BCeSIS No._____

Name: _____ (**Male/Female**) D.O.B._____/_____/_____ Grade: _____
Last Name *First Name* *year month day*

Languages Spoke

Parent(s)/Guardia

Address: _____

Doctor: _____

Parent/Guardian e

FILLABLE FORM AVAILABLE ON ABBY CONNECT
https://abbyconnect.sd34.bc.ca/ (LSS Department – scroll down to forms)

Reason for Refer

_____

_____

_____

Intervention(s):

1._____

_____

2._____

_____

Check the service Requested by SBT (*see chart on reverse for supporting documentation required)

- ❑ District Elementary Counsellor
- ❑ District Youth Care Worker
- ❑ Speech/Language Assessment/Consultation
- ❑ Language Literacy Middle School SLP
- ❑ Augmentative & Alternative Communication SLP
- ❑ School Psychologist Assessment/Consultation
- ❑ Hearing Services
- ❑ Vision Services
- ❑ Learning and Assessment Centre
- ❑ Occupational Therapy
- ❑ Physiotherapy
- ❑ Special Education Technology – BC (SET-BC)
- ❑ Provincial Integration Support Program (PISP)
- ❑ Other _____

Other Relevant Information (including involvement of other professionals/agencies)

_____

_____

Signatures: Principal: _____ SBT Case Manager:_____ Date:_____

INFORMED CONSENT: A parent/guardian gives **written** consent to receive a proposed service following a process of decision-making leading to an informed choice. The parent/guardian has been provided with sufficient information to make the decision, **including the benefits and risks, and the possible alternatives to the proposed service**, and the parent/guardian understands the information. The parent/guardian can withdraw informed consent at any time.

Freedom of Information and Protection of Privacy Act: The information collected on this form will be protected under the provisions of this act. The information will be shared for educational program purposes and if legally required by section 79 (2) of the School Act, may be provided to health services, social services, or other support services.

As parent/guardian, I give my consent for my child to receive the support service(s) indicated above.

LSS Referrals – Departmental Supporting Documentation for Referrals

Social Dev. Team (Counselling/Beh. Support) ❑ LSS Referral Form	**School Psychologist** ❑ LSS Referral Form (this form) ❑ Parental Consent for Assessment ❑ School Based Screening results (e.g. KTEA or KBIT etc.) ❑ Copy of Last Report Card ❑ School record ❑ IEP, if available ❑ Previous Assessments & Reports ❑ Vision/Hearing Screening
Speech Langu ❑ LSS Referr	DC) d by CDC)
SET-BC ❑ LSS Referr ❑ Parent Con ❑ District Scr (contact Di	forms)
Hearing ❑ LSS Referral Form	**Vision** ❑ LSS Referral Form ❑ Parent package forms
Learning and Assessment Centers Please refer to pg.10:28 of Quick Reference Guide	

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Referral to Learning Support Services Process

Although there is no requirement for written permission from parents to discuss their child at SBT, they should be informed verbally.

Referral Form Process

a) SBT has determined a need for a service from an LSS department
b) Parent is informed about the service and signs the **Referral Form**.
c) Completed forms and referral packages* are sent to appropriate department or helping teacher (see back of the referral form).
d) Departments will complete the **"For Office Use Only**" section and will return 2 carbon copies for the school and parent.

***Referral Packages** – To avoid delays in processing referrals, please ensure that all the documents required are completed appropriately. Use the information on the back of the referral form as a checklist to ensure all the necessary paperwork is included in the referral package.

Fraser Valley Child Development Centre

REFERRAL FOR SERVICES

Has the parent or legal guardian consented to this referral? ❒ YES ❒ NO
This referral will not be processed without parental/legal guardian consent.

CHILD'S LAST NAME, FIRST NAME ❒ FEMALE ❒ MALE		DATE OF REFERRAL		DATE OF BIRTH (DD/MM/YYYY)
FIRST LANGUAGE (*If not English*)	INTERPRETER REQD. ❒ YES ❒ NO	HOUSE ADDRESS (WHERE THE CHILD RESIDES)		
ABORIGINAL ❒ YES ❒ NO	PARENT/GUARDIAN/FOSTER PARENT	RELATIONSHIP TO CHILD	LEGAL GUARDIAN Yes ❒ No ❒	PERSONAL HEALTH #
MAILING ADDRESS (If not same as above), POSTAL CODE			HOME PHONE:	WORK PHONE/CELL:
NAME OF PRESCHOOL, DAYCARE, SCHOOL	CONTACT NAME	PHONE NO:	PHYSICIAN:	
SOCIAL WOR				
ADDRESS:				
REASON FOR				
MEDICAL DIAGNOSIS: ❒ YES ❒ NO – IF YES, SPECIFY:				
HOME VISIT OR HEALTH/SAFETY CONCERNS: ❒ YES ❒ NO – IF YES, SPECIFY:				
REFERRED BY (Please print name):			PHONE #	
RELATIONSHIP AND/OR FACILITY		ADDRESS/POSTAL CODE		
FORM COMPLETED BY:		ORIGINAL DATE OF REFERRAL (DD/MM/YY):		

FILLABLE FORM AVAILABLE ON ABBY CONNECT
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(LSS Department – scroll down to forms)

The private and personal information collected on this form is used to determine eligibility and appropriateness of services to be provided. Nonidentifying statistical information may be collected, collated and distributed to support requests for funding, advocacy, resource allocation and measuring outcomes. Please refer to the Fraser Valley Child Development Centre Personal Information Protection Act Policy.

Revision date: August 19, 2009

Abbotsford Office
102-32885 Ventura Ave
Abbotsford, BC
V2S 6A3
Tel: (604) 852-2686
Fax: (604) 852-5794

Chilliwack Office
45474 Luckakuck Way
Chilliwack, BC
V2R 3S9
Tel: (604) 824-8760
Fax: (604) 824-8735

Hope Office
1250 7th Ave
Hope, BC
V0X 1L0
Tel: (604) 869-5467
Fax: (604) 869-2994

Mission Office
4-7337 Welton St
Mission, BC
V2V 3X1
Tel: (604) 820-9536
Fax: (604) 820-9568

Website: www.fvcdc.org

Fraser Valley
Child Development Centre

CONSENT FOR SERVICE

I, the undersigned parent or guardian of the child _____,

PHN # _____ Date of birth: _____,

do hereby consent to his/her assessment, treatment and/or other service provided by the Fraser Valley Child Development Centre. I understand that the FVCDC's model of service requires parents/guardians to become actively involved in enhancing and enriching their child's development.

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Nonidentifying s…ests for funding, advoca…

I will be informe…y child's continued servic…

☐ Yes ☐ N…dents, and I …ogram.

☐ No …iling list to receive newsletters and information regarding other FVCDC special events and activities.

_____ _____
Date Signature

_____
Printed Name

_____
Printed Address

_____
Postal Code

_____
Phone Numbers (Home and Work)

_____
Witness (a non-family member please)

Helping Kids Shine

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Abbotsford, BC V2S 6A3
Tel: 604.852.2686
Fax: 604.852.5794

Chilliwack Office
45474 Luckakuck Way
Chilliwack, BC V2R 3S9
Tel: 604.824.8760
Fax: 604.824.8735

Hope Office
P.O. Box 2077
Hope, BC V0X 1L0
Tel: 604.860.7731
Fax: 604.869.2994

Mission Office
4–7337 Welton St.
Mission, BC V2V 3X1
Tel: 604.820.9536
Fax: 604.820.9568

www.fvcdc.org

Fraser Valley Child Development Centre

Consent to Obtain/Release Information

By completing this form, you are giving FVCDC consent (as indicated) to collect, use and disclose information for the purposes of providing appropriate assessment(s) and service(s) to your child.

Please initial and give the name and address of all pertaining persons/agencies.
By signing this consent to obtain/release information, it will VOID ALL PREVIOUS CONSENTS on file.

Initials Only Obtain	Release		FVCDC Staff Use Please check if Admin to obtain info
____	____	School District (**must specify**) School Name _____	☐
____	____	Private School (**must specify**) Private School Name: _____	☐
____	____		☐
____	____		☐
____	____		☐
____	____		☐
____	____	(**must specify** if other than FVCDC) Address: _____	☐
____	____	BC Women's & Children's Health Centre	☐
____	____	Sunny Hill Health Centre	☐
____	____	Health Unit _____ _____	☐
____	____	My Child's Physician(s) (**must specify family physician or specialist**)	
		Name: _____ Name: _____ Address: _____ Address: _____	☐
____	____	Ministry of Child & Family Development (**must specify**) Name: _____ Address: _____	☐
____	____	Other (**must specify**) Name: _____ Name: _____ Address: _____ Address: _____	☐

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Name of Child

Signature of Parent/Legal Guardian authorized to give consent

Child's Birth Date

Relationship to Child

PHN Number (care card)

Address

Date

Signature of Witness

FVCDC Forms- July 2007

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Telephone: (604) 852-2686 Fax: (604) 852-5794